STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035092	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Vita Health and Rehabilitation Center	5125 North 58th Avenue Glendale, AZ 85301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, facility documentation, policy review, and the State Agency complaint tracking system, the facility failed to ensure that one resident (#1) was not neglected by failing to assess and meet their basic needs to prevent the development of a Stage 3 pressure ulcer and Deep Tissue Injury (DTI). The deficient practice could result in the residents' development of pressure ulcers and deep tissue injuries. Findings include:Resident #1 was admitted to the facility on [DATE], with diagnoses that included hypertension, Diabetes Mellitus (DM) Type 2, Schizophrenia, Non-Alzheimer's Dementia, and Cerebrovascular Accident (CVA) with a left-sided weakness.On May 9, 2025, a Braden Scale for Predicting Pressure Sore Risk assessment was completed, and the resident's score was 10.0, high risk.A review of a document, Skin Evaluation-PRN/Weekly, dated May 10, 2025, revealed an initial admission skin evaluation by a wound nurse. The skin evaluation revealed the resident's bilateral feet were dry and flaky; toenails were elongated and thick, with the left great toenail having dark discoloration; right groin with multiple dry, dark brown colored thick nodules; left hand with slight purple discoloration; and a bruising sacrum, pink and blanchable.Another Braden Scale for Predicting Pressure Sore Risk assessment was completed on May 10, 2025, and the resident's score was 13.0, moderate risk.A review of a document, Skin Check - Shower Sheets, dated May 10, 2025, revealed the Resident had a full assist shower, and there were no bruises, skin tear, red areas, open areas, rashes, or unusual marks noted.A review of the Nutrition-admission Evaluation assessment dated [DATE], revealed the resident had an order for regular mechanical soft diet, thin fluid consistency, no supplement ordered; resident's weight on May 10, 2025 using a wheelchair scale was 195.8 pounds; have upper and lower dentition; feeds self; skin status was intact; had a Body Mass Index (BMI) of 28.1, overweight; and the resident was at risk of malnutrition per the Minimum Nutrition Assessment (MNA) due to decreased mobility from CVA, Schizophrenia, diabetes, and dysphagia.A review of the resident's care plans dated May 13, 2025, revealed the following focus:-The resident has a pressure ulcer or potential for pressure ulcer development related to neurocognitive, CVA, bipolar, and diabetes mellitus. The interventions included administering medications and treatments as ordered; monitoring for effectiveness; daily body checks; notifying the nurse immediately of any new areas of skin breakdown noted during bath or daily care; and using pressure-relieving/reducing device, float heels as the resident allows and as tolerated; and-The resident has Diabetes Mellitus. The goal was to have no complications related to diabetes. And, the interventions included checking the body for breaks in skin and treating promptly as ordered by the doctor; checking skin when assisting with ADLs; inspecting feet daily for open areas, sores, pressure areas, blisters, edema or redness, and report any of the above to the nurse; monitor, document, report to the medical doctor as needed for signs and symptoms of infection to any open areas, redness, pain, heat, swelling or pus formation; and refer to podiatrist or foot care nurse to monitor, document foot care needs and to cut long nails.Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 0.0; did not exhibit behavioral symptoms; did not exhibit rejection of care or wandering behavior; the resident was assessed as having impairment on both upper and lower extremities, had functional limitation in range of motion that interfered with daily function or placed the resident at risk of injury; the resident was mostly dependent for oral, personal, shower/bathe, lower and upper body dressing, and toileting hygiene; the resident was dependent on staff to assist with rolling left and right while in bed; the resident was dependent on staff for chair/bed-to-chair transfer; and the resident was always incontinent of urine and bowel. In addition, the MDS revealed that the resident did not have unhealed pressure ulcers/injuries, but was at risk of developing pressure ulcers/injuries, and the resident does not have a condition or chronic disease that may result in a life expectancy of less than six months.Additional review of the document Skin Check - Shower Sheets dated May 16, 2025, revealed that the Resident had a full assist shower and no bruises, skin tear, red areas, open areas, rashes, or unusual marks were noted.Another review of the care plan dated May 17, 2025, revealed the resident has bowel and bladder incontinence related to impaired mobility. The interventions included checking as required for incontinence; washing, rinsing, and drying the perineum; and changing clothes as needed after incontinence episodes.A review of a document, Skin Evaluation-PRN/Weekly, dated May 17, 2025 and May 23, 2025, revealed there was no new skin issue noted.Another review of the document Skin Check - Shower Sheets dated May 24, 2025, revealed that the Resident had a shower, and no bruises, skin tear, red areas, open